



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

BAYLOR MEDICAL CENTER AT TROPHY CLUB

Respondent Name

CITY OF FORT WORTH

MFDR Tracking Number

M4-17-1910-01

Carrier's Austin Representative

Box Number 04

MFDR Date Received

February 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services."

Amount in Dispute: \$396.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The implant line was denied needed the certification of cost statement. . . . the requested information for item . . . has not been received to date therefore Wellcomp stands on the reconsideration and feels no additional is due . . ."

Response Submitted by: WellComp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2016 to June 14, 2016	Outpatient Hospital Services	\$396.34	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
 - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 251 - THE ATTACHMENT CONTENT RECEIVED DID NOT CONTAIN THE CONTENT REQUIRED TO PROCESS THIS CLAIM OR SERVICE.
 - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
 - P14 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has performed on the same day.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes
 - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
 - 251 – THE ATTACHMENT CONTENT RECEIVED DID NOT CONTAIN THE CONTENT REQUIRED TO PROCESS THIS CLAIM OR SERVICE.

28 Texas Administrative Code §134.403(g), requires that:

Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission.

Review of the submitted information finds no documentation to support an invoice amount for the implantable item "anchor sut 4.75mm x 19.1" (as labeled on the itemized statement). The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended for this item.

2. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are \$2,186.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.

3. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov. Reimbursement for the disputed services is calculated as follows:
- Procedure code C1713 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services. This line includes implantable items paid separately below. The charges for the separately paid implantable items have been deducted from the gross charges for the purpose of calculating any outlier payments.
 - Procedure codes 36415, 80048, 81001, 85025 and 81015 have status indicator Q4, denoting packaged labs. Separate payment allowed at Clinical Lab Fee Schedule rates if the bill contains only status Q4 HCPCS codes listed in the CLFS; otherwise, payment for these labs is included with reimbursement for the primary service(s).
 - Procedure code 27698 has status indicator T, denoting significant procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 100%. This is assigned APC 5122. The OPPS Addendum A payment rate is \$2,395.59. This is multiplied by 60% for an unadjusted labor-related amount of \$1,437.35, which is multiplied by the facility's annual wage index of 0.9731 for an adjusted labor amount of \$1,398.69. The non-labor related portion is 40% of the APC rate, or \$958.24. The sum of the labor and non-labor portions is \$2,356.93. The cost of these services does not exceed the fixed-dollar threshold of \$3,250. The outlier payment is \$0. The Medicare facility specific reimbursement for this line of \$2,356.93 is multiplied by 130% for a MAR of \$3,064.01.
 - Procedure codes J0690, J1170, J1885, J2175, J2405 and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission." Review of the submitted documentation finds the following implantables:
- "INTERNAL BRACE LIGAMENT" as labeled on the invoice with a cost per unit of \$1,536.00;
 - "SUTR ANCH, BIO-COM S-TAK SM INT" as labeled on the invoice with a cost per unit of \$325.00 at 2 units, for a total cost of \$650.00.
- The total net invoice amount (exclusive of rebates and discounts) is \$2,186.00. The total add-on amount of 10% or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission is \$218.60. The total recommended reimbursement amount for the implantable items is \$2,404.60.
5. The total recommended reimbursement for the disputed services is \$5,468.61. The insurance carrier has paid \$5,512.27 leaving an amount due to the requestor of \$0.00. Additional payment is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	Grayson Richardson	March 24, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.